| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|-------------|---|------------------------------------|
| AND PLAN | OF CORRECTION | 155305 | A. BUILDING | | 03/24/2011 |
| | | 1 | B. WING | | |
| NAME OF F | PROVIDER OR SUPPLIE | ₹ | l | ADDRESS, CITY, STATE, ZIP CODE NINTH STREET | |
| SKILLED | CARING CENTER | R OF MEMORIAL HOSPITAL | l l | R, IN47546 | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | NCY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | REGULATORY OR | LISC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| F0000 | This visit was for State Licensure of Survey dates: Market Number: 1 Survey Team: Brenda Buroker: Debora Barth, R. Donna Downs, F. Lois Corbin, R. M. Census Bed Typ SNF/NF: 13 Total: 13 Census Payor Tymedicare: 12 Other: 1 Total: 13 Stage 2 Sample: These deficience of findings in according to the state of the state | March 22, 23, 24, 2011 :: 000202 ::: 155305 00284870 ; RN TC N RN I e: 16 es also reflect state rdance with 410 IAC 16.2. completed 3-28-11 | F0000 | Credible Allegation of complia and correction:Preparation and execution of this response an plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becautis required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, response and plan of correctic constitutes the facilities allegation of compliance in accordance assection 7305 of the State Operations Manual. | d d the se it of e at this on tion |
| | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Page 1 of 18

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GYAS11 000202 If continuation sheet

TITLE

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|---|----------------------|------------------------------|-------------|--------|---|---------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | | COMPLETED | |
| | | 155305 | B. WIN | | | 03/24/2011 | |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | l | NINTH STREET | | |
| | CARING CENTER | OF MEMORIAL HOSPITAL | | | R, IN47546 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | TΕ | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| F0156 | Based on interv | view and record review, | F01 | 56 | | | 04/23/2011 |
| | | d to ensure notification | | | Describe what the facility discount is a second of the second of th | | |
| SS=A | for non-coverage | | | | to correct the deficient practice for each client cited in the | • | |
| | | rovided two days prior | | | deficiency. Facility policy for | | |
| | | | | | "Notification of Medicare Denia | al of | |
| | | ervices for one of one | | | Covered Services in the Skiller | | |
| | | ficiaries discharged in | | | Caring Center and Financial | | |
| | | hs who was reviewed | | | Responsibility" was revised on | · | |
| | for required dis | charge from skilled | | | 3/24/11 at 10:30am. See Exhi | | |
| | service informa | ition. The facility also | | | A. The policy revision states ". | | |
| | failed to include | e the name and phone | | | Notification of the determination | | |
| | number of the (| Quality Improvement | | | of non-covered status is given | | |
| | Organization or | • | | | least two business days prior t | :0 | |
| | _ | der non-coverage. | | | the resident's termination of services." The "Notice of | | |
| | (Resident #34) | der non coverage. | | | Medicare Provider | | |
| | (1163146111 #34) | | | | Non-Coverage" form (OMB | | |
| | | | | | approval No. 0938-0953) was | | |
| | Findings includ | e: | | | revised on 3/24/11 at 11:15am | | |
| | | | | | See Exhibit B. The form revisi | on | |
| | | ical record of Resident | | | includes under "How to ask for | | |
| | #34 was review | ved on 3/23/11 at 10:00 | | | immediate appeal Bullet # 4", t | | |
| | a.m. The resid | ent's record included a | | | name and number of the Qual | | |
| | copy of the "No | tice of Medicare | | | Improvement Organization in t | ne | |
| | | Coverage" (OMB | | | event the resident and/or representative wished to appe | _{al} | |
| | | 938-0953) signed by | | | the decision. The revised form | | |
| | | epresentative and the | | | states "Call your QIO at: | | |
| | | on 11/18/2010. The | | | 800-288-1499 (Health Care | | |
| | | | | | Excel) to appeal, or if you have | e | |
| | notice indicated | | | | questions." Facility contacted | | |
| | | of coverage of skilled | | | Health Care Excel facilities | . | |
| | ~ | s would end on | | | manager and they stated they | | |
| | | notice did not include | | | not have a TTY number to incl on our form. The Medicare TT | | |
| | the name and r | number of the Quality | | | number is included on the forn | - | |
| | Improvement C | Organization in the | | | On 3/24/11 at 11:30am, Social | | |
| | event the reside | ent and/or | | | Worker and Director of Nursing | | |
| | representative | wished to appeal the | | | educated on the revised policy | ~ I | |
| | decision. | | | | and form and instructed to beg | | |
| | | | | | utilizing immediately as warrar | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION | | | X3) DATE SURVEY | |
|--|--|--|----------------------------|---------|--|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING CC | | | COMPL | ETED |
| | | 155305 | B. WIN | | | 03/24/2 | 011 |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | ₹ | | | NINTH STREET | | |
| SKII I ED | CADING CENTED | OF MEMORIAL HOSPITAL | | | R, IN47546 | | |
| | CANING CENTER | O WEWORIAL TIOSI TIAL | | JAOI LI | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | l ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | The current po Medicare Denia in Skilled Carin Responsibility, provided by the 3/23/11 at 3:05 following: "Purpose: To provide a monotice to a Medical or her guaranto decision is made and decision is made and the skilled Director of Nurrector of Nurr | licy for "Notification of al of Covered Services of Center and Financial "dated 3/10, was e Administrator on p.m. and indicated the ethod for giving written dicare patient and his or when a non-covered de | | | for residents. 2. Describe how the facility reviewed all clients the facility that could be affect by the same deficient practice and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. Resident # 34 was the only resident who no longer met the "Medicare Guidelines for Cove Care" which warranted notification of "Medicare Denial Covered Services" as of 04/07 No other residents have require notification as of 04/07/11. Fact policy for "Notification of Medic Denial of Covered Services in Skilled Caring Center and Financial Responsibility" was revised on 3/24/11 at 10:30am. See Exhibit A. The policy revision states " Notification of the determination of non-covered status is given least two business days prior the resident's termination of services." The "Notice of Medicare Provider Non-Coverage" form (OMB approval No. 0938-0953) was revised on 3/24/11 at 11:15am See Exhibit B. The form revisincludes under "how to ask for immediate appeal Bullet # 4", name and number of the Qual Improvement Organization in the event the resident and/or representative wished to appet the decision. The revised form states "Call your QIO at: | in ed , cility et ered al of 7/11. The cility care the on at to ion an the cility che al | |
| | | | | | , | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
|---|---------------------|------------------------------|----------------------------|-------------|---|-------------------------------|------------|
| 11112 12111 | or condition. | 155305 | | A. BUILDING | | 03/24/2011 | |
| | | <u> </u> | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | NINTH STREET | | |
| SKILLED | CARING CENTER | R OF MEMORIAL HOSPITAL | | 1 | R, IN47546 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | | DATE |
| | | ider Non-Coverage, | | | 800-288-1499 (Health Care | _ | |
| | | cms.gov on 3/23/11 at | | | Excel) to appeal, or if you have questions." On 3/24/11 at | = | |
| | 8:00 p.m., inclu | uded, but was not | | | 11:30am, Social Worker and | | |
| | limited to, the f | following: | | | Director of Nursing educated of | on | |
| | | | | | the revised policy and form an | | |
| | "A Medicare pr | ovider must give a | | | instructed to begin utilizing | | |
| | | y of this notice to | | | immediately as warranted for | | |
| | | eceiving services from | | | residents. 3. Describe the ste | | |
| | | facilities (SNFs), home | | | or systemic changes the facilit has made or will make to ensu | • | |
| | health agencie | , , | | | that the deficient practice does | - | |
| | comprehensive | • | | | not recur, including any | , | |
| | | • | | | in-services, but this also shoul | d | |
| | | acilities (CORFs), or | | | include any system changes y | ou | |
| | | er than 2 days before | | | made. Revised and instituted t | | |
| | | of services. This | | | following policy. "Notification of | of | |
| | | e requirement at 42 | | | Medicare Denial of Covered | 4 | |
| | CFR 405.1200 | (b)." | | | Services in Skilled Caring Cen and Financial Responsibility". | | |
| | | | | | Exhibit A. Revised and institut | | |
| | "How to ask fo | r an immediate appeal | | | the "Notice of Medicare Provid | | |
| | Bullet # 4 Inse | rt the name and | | | Non-Coverage" form (OMB | | |
| | telephone num | bers (including TTY) of | | | approval No. 0938-0953) was | | |
| | the applicable | QIO in no less than | | | revised on 3/24/11 at 11:15am | | |
| | 12-point type." | | | | See Exhibit B. On 3/24/11 at | | |
| | ' '' | | | | 11:30am, Social Worker and | | |
| | Durina intervie | w with the | | | Director of Nursing educated the Administrator on the revise | • | |
| | ' ' ' ' ' | on 3/24/11 at 8:10 a.m., | | | policy and form and instructed | | |
| | | hey had issued the | | | begin utilizing immediately as | | |
| | | Medicare Denial of | | | warranted for residents. 4. | | |
| | | ces to Resident #34 on | | | Describe how the corrective | | |
| | | | | | action(s) will be monitored to | | |
| | | n-covered status, and | | | ensure the deficient practice w | /111 | |
| | | olicy indicated one | | | not recur, i.e., what quality assurance program will be put | | |
| | business day v | vas required. | | | into place. Health Information | | |
| | 2.4.4(5)(2) | | | | Representative will review all | | |
| | 3.1-4(f)(3) | | | | Medicare Denials that are give | en | |
| | | | | | to residents as warranted to | | |
| | | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| LAND DE AN OF CORRECTION INDENTIFICATION AND OFFI | IA (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|--|---------------------|--|----------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155305 | A. BUILDING | | COMPLETED 03/24/2011 |
| 133303 | B. WING | ADDRESS STEEL STEE | 00/24/2011 |
| NAME OF PROVIDER OR SUPPLIER | | ADDRESS, CITY, STATE, ZIP CODE NINTH STREET | |
| SKILLED CARING CENTER OF MEMORIAL HOSPIT | TAL JASPE | R, IN47546 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FI | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION |
| TAG REGULATORY OR LSC IDENTIFYING INFORMAT | I | ensure 2 days notice has bee given as written in policy and a "Notice of Medicare Provider Non-coverage" form has the C information included. Monitority will be on-going. | DATE n the |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | | |
|--|-------------------------|------------------------------|-------------|--------|--|-----------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | | COMPLETED | | |
| | | 155305 | B. WING | | | 03/24/2 | 3/24/2011 | |
| | | | D. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | NINTH STREET | | | |
| SKII I ED | CADING CENTED | OF MEMORIAL HOSPITAL | | | R, IN47546 | | | |
| | | | | | | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | * | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | · | | DATE | |
| F0329 | | view and record review | F03 | 29 | Describe what the facility did to | | 04/23/2011 | |
| SS=D | the facility failed | d to ensure | | | correct the deficient practice for each client cited in the deficier | | | |
| | psychoactive d | rugs were only given | | | On 3/24/11 a draft policy was | icy. | | |
| | after other inter | ventions had been | | | initiated for Utilization of | | | |
| | attempted in ar | effort to avoid | | | Psychotropic medications. At | | | |
| | unnecessary dr | | | | 4:45pm educational informatio | n | | |
| | • | wed who met the | | | was sent to the Skilled Caring | | | |
| | | hoactive drugs in a | | | Center's nurses via e-mail to | | | |
| | | Residents #125 and | | | address the utilization of | | | |
| | 130] | residents #120 and | | | psychoactive medications. Emphasis was placed on | | | |
| | 130] | | | | providing alternative intervention | ons | | |
| | Circulina and incolored | | | | prior to the administration of a | | | |
| | Findings includ | e: | | | psychotropic medication and the | | | |
| | | | | | method to document this in the | e | | |
| | 1. The clinical | record for Resident | | | medical record.On 3/24/11 at | | | |
| | #125 was revie | wed on 3/23/11 at | | | 5:00pm, all resident's with | | | |
| | 10:53 A.M. and | indicated the | | | physician orders for psychotro | | | |
| | resident was a | dmitted to the facility | | | medications were reviewed by Director of Nursing for clinical | uie | | |
| | on 3/18/11. Th | e physician orders | | | justification of these | | | |
| | | included Lorazepam | | | medications.On 3/28/11 a new | , | | |
| | [also know as | | | | policy for Psychotropic Utilizati | ion | | |
| | - | dication] 2 mg HS | | | was developed and initiated. T | | | |
| | • | - · · | | | new policy was posted for all s | taff | | |
| | | ns at bedtime as | | | to review. See Exhibit C 2. | | | |
| | needed.] | | | | Describe how the facility review | | | |
| | | | | | all clients in the facility that cou be affected by the same defici- | | | |
| | | medication record | | | practice, and state, what action | | | |
| | • | ed the resident had | | | the facility took to correct the | | | |
| | been administe | red the medication on | | | deficient practice for any client | : | | |
| | 3/21/11 at 10:5 | 3 P.M. and 3/21/11 at | | | the facility identified as being | | | |
| | 2:10 A.M. | | | | affected. On 3/24/11 a draft po | licy | | |
| | | | | | was initiated for Utilization of Psychotropic medications. At | | | |
| | A nurses note of | on 3/21/11 at 5:19 A.M. | | | 4:45pm educational informatio | n l | | |
| | | orazepam had been | | | was sent to the Skilled Caring | | | |
| | | and the resident "has | | | Center's nurses via e-mail to | | | |
| | • | adm [administration of | | | address the utilization of | | | |
| | not diopt diriot | aa [aaaa.aa.aa. | | | | | | |

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|-----------|--|----------------------------------|----------------------------|--------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | LDING | | COMPL | ETED |
| | | 155305 | B. WIN | LDING | | 03/24/2 | 011 |
| | | 1 | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF | PROVIDER OR SUPPLIEI | R | | 1 | NINTH STREET | | |
| GKII I EL | CADING CENTER | R OF MEMORIAL HOSPITAL | | 1 | R, IN47546 | | |
| | CARING CENTER | OF WEWORIAL HOSFITAL | | JASEL | | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | ICIENCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | COMPLETION |
| TAG | + | R LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | | DATE |
| | ativan]." | | | | psychoactive medications. | | |
| | | | | | Emphasis was placed on | | |
| | There was an | entry by the nurse who | | | providing alternative intervent prior to the administration of a | | |
| | administered tl | ne 3/21/11 Lorazepam | | | psychotropic medication and | - | |
| | | drug was given the | | | method to document this in th | | |
| | resident was re | | | | medical record.On 3/24/11 at | | |
| | | | | | 5:00pm, all resident's with | | |
| | There was no | indication what other | | | physician orders for psychotro | | |
| | | ad been attempted to | | | medications were reviewed by | / the | |
| | | • | | | Director of Nursing for clinical | | |
| | help the resident with insomnia before | | | | justification of these medications.On 3/28/11 a new | ., | |
| | giving the drug | on 3/23/11. | | | policy for Psychotropic Utiliza | | |
| | | | | | was developed and initiated. | | |
| | Interview with | the DoN on 3/24/11 at | | | new policy was posted for all | | |
| | 9:30 A.M. indic | cated the electronic | | | to review. See Exhibit C 3. | | |
| | record system | had a screen for the | | | Describe the steps or systemi | С | |
| | nurses to docu | ment what other | | | changes the facility has made | or | |
| | | vere attempted prior to | | | will make to ensure that the | | |
| | | a psychoactive drug. | | | deficient practice does not rec | | |
| | _ | he screen for review. | | | including any in-services, but | | |
| | 1 ' | only checked the box | | | also should include any syste changes you made. On 3/28/ | | |
| | | • | | | new policy for Psychotropic | ii a | |
| | _ | resident was medicated | | | Utilization was developed and | | |
| | | d not checked any other | | | initiated. The new policy was | | |
| | | the medication dates | | | posted for all staff to review. | See | |
| | of 3/21/11 and | 3/23/11. | | | Exhibit C On 4/1/11 education | nal | |
| | | | | | flyer was sent to all staff via e | | |
| | 2. The clinical | record for Resident | | | and was posted in the confere | | |
| | #130 was revie | ewed on 3/23/11 at | | | room and at the nurse's statio | n. | |
| | 11:30 A.M. and | d indicated Xanax [an | | | See Exhibit D Beginning | th | |
| | | dication] and Ambien [a | | | 4/18/11, residents admitted will orders for psychotropic | u I | |
| | 1 | cation] were ordered on | | | medications will be provided | | |
| | admission on 3 | <u>-</u> | | | education regarding type of | | |
| | | <i>7</i> 1 1 1 1 1 1 1 . | | | medication, indications of usa | ge, | |
| | The clinical rad | pard indicated as | | | most common potential side | | |
| | | cord indicated on | | | effects and rationale for | | |
| | ر عاری از از عاری از ع | c 0.25 mg was given at | | | attempting alternative | | |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | | |
|--|---|--------------------------------|--------------|---|---------------------------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | COMPLETED | |
| | | 155305 | B. WING | | 03/24/2011 | |
| | | | | ET ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | 800 \ | W NINTH STREET | | |
| SKILLED | CARING CENTER | R OF MEMORIAL HOSPITAL | JASF | PER, IN47546 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | |
| PREFIX | · ` | NCY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE | RIATE | |
| TAG | | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE . | |
| | | inxiety. On 3/22/11 at | | interventions. Nurses are be | | |
| | | ax 0.25 mg was given | | educated on new procedure to their next assigned shift. | · | |
| | for insomnia. | Ambien had been given | | Exhibit E The Director of Nu | I | |
| | 3/21/11 and 3/2 | 22/11. | | will provide additional | 11303 | |
| | | | | in-service/education training | | |
| | According to th | ne documentation in the | | during annual competencies | | |
| | | rd, on 3/18/11 at 1:22 | | all Skilled Caring Center nur | | |
| | | ent exhibited anxiety, | | that are scheduled 4/11/11, | | |
| | | ation was given. The | | 4/19/11, 4/20/11 and 4/22/11 | I | |
| | | <u> </u> | | Information will include revie | • • • • • • • • • • • • • • • • • • • | |
| | record indicated the other intervention used was "position change." | | | current policies entitled Free | | |
| | | | | from Unnecessary Drugs, S Exhibit F; Use of Antipsycho | | |
| | | | | Drugs, See Exhibit G, and t | • • • • • • • • • • • • • • • • • • • | |
| | | w with the DoN at 9:13 | | new policy on Psychotropic | | |
| | | 1, she indicated she | | Utilization.On 4/18/11 the He | ealth | |
| | reviewed the c | are plan for the | | Information representative v | • • • • • • • • • • • • • • • • • • • | |
| | resident. She | located documentation | | begin utilizing a work sheet | during | |
| | in the electroni | c record related to the | | the admission chart review t | | |
| | two dates the r | resident was given the | | address potential unnecessa | ary | |
| | | re was a place for the | | medications. See Exhibit H | | |
| | | other interventions | | This information will be relay the nurses. Nurses will be | red to | |
| | | | | responsible to verify the | | |
| | | ving the drug. The only | | justification of all psychotrop | ic | |
| | | ecked was medicate | | medications prescribed.On | ·- | |
| | | Ouring the interview, the | | 4/26/11 an updated Health (| Care | |
| | 1 | the Ambien was | | Plan Conference Summary | • • • • • • • • • • • • • • • • • • • | |
| | | ely and not as a prn, or | | to be implemented | | |
| | as needed, dru | ıg. She was unable to | | that addresses the use of | | |
| | indicate what t | he facility policy was | | psychotropic medications. S | | |
| | regarding adm | inistering routine | | Exhibit I 4. Describe how th | e | |
| | hypnotic drugs | - - | | corrective action(s) will be monitored to ensure the defi | cient | |
| | ' | | | practice will not recur, i.e., w | I | |
| | Interview with | the DoN and | | quality assurance program v | I | |
| | | on 3/24/11 at 9:30 A.M. | | put into place. The consulta | I | |
| | 1 | nly policy the facility | | pharmacist will complete mo | onthly | |
| | | , , , | | reviews to address psychotr | opic | |
| | i nau ior psycho | active drugs was the | | medications as well as for | | |

000202

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155305 | | (X2) MULTIPLE CO A. BUILDING | ONSTRUCTION | (X3) DATE SURVEY COMPLETED 03/24/2011 | | |
|---|--|---|---------------------|--|--|----------------------------|
| | PROVIDER OR SUPPLIER | | 800 W | ADDRESS, CITY, STATE, ZIP CODE NINTH STREET ER, IN47546 | 1 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | IATE | (X5) COMPLETION DATE |
| | policy for chemof the policies in to ensure antial drugs were given interventions have | tropic drug use and a nical restraint. Neither indicated a procedure inxiety and hypnotic en only after other ad been tried and with ation for their use. | | unnecessary medications. A of recommendations will be a report of the findings will be reported to the Administrator Administrator will monitor compliance on an ongoing be and either the Administrator Consulting Pharmacist will refindings at the quarterly Quarksessment/ Performance Improvement committee. Committee mem will monitor overall effectiver and make recommendations needed. The Director of Nurse will conduct monthly random monitoring of psychotropic alternative documentation to ensure nurses are offering alternative interventions prior administration of any psychotropic medications. Monitoring will be 5 random a month for 2 months, then 2 times a month for 4 months be re-evaluated at the quarter Quality Assessment/ Performance Improvement of ittee. See Exhibit J | kept. e c.The asis or the eport lity abers ass es r to times then erly | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155305 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | ONSTRUCTION | (X3) DATE SURVEY COMPLETED 03/24/2011 | |
|--|--|---|--|---------------|--|---|---------------------------------|
| | PROVIDER OR SUPPLIER | OF MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 800 W NINTH STREET JASPER, IN47546 | | | | |
| (X4) ID PREFIX TAG F0441 | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | F04 | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) 1.Describe what the facility did to correct the | Ē | (X5) COMPLETION DATE 04/23/2011 |
| SS=E | interview, review, the to ensure free of post contaminated glucometed 13 resider diabetic are accucheck monitoring #21, #122 and #129) Findings in On 3/24/11 during observations of the DoN (contaminated) | | | | deficient practice for each client cited in the deficiency. On 3/24/11 the facility received list of approved disinfectants frequency the manufacturer (Roche) of the Accu-chek machines. The PDI Super Sani-cloth was approved use to clean AND disinfect the machines. The facility checked the FDA website and the ingredients in the PDI Super Sani-cloths are recommended disinfecting. (FAQ on PDI Super Sani-cloth and a fax from Roch on acceptable active disinfecting solutions to use on the Accu-cinform system). (See Exhibit Heand L) The facility had the PDI Super Sani-cloths in stock and prior to the next set of Accu-cheks that were performed. On 3/24/11 at 3:30 all Accu-chek machines were disinfected with PDI Super Sani-cloths. The two Accu-chek machines that are used in the facility were disinfected with the PDI Super Sani-Cloths between each remaining resid (Resident #122, #126, #127 and #129) (Resident #21 was discharged therefore was no longer an issue.) who required glucose monitoring. The Administrator and Director of Nursing began educating all nurses on 03/24/11 at 3:30pm. (See Exhibit M) In addition, a memo regarding the change in procedure regarding the disinfecting of | formine d to d for ereng hek () I pm ni ent | V-1/23/2011 |

| NAME OF PROVIDER OR SUPPLIER SKILLED CARING CENTER OF MEMORIAL HOSPITAL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COM- | (X3) DATE SURVEY | |
|---|------------------|--|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 W NINTH STREET JASPER, IN47546 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Time, "the glucometers were used for all STREET ADDRESS, CITY, STATE, ZIP CODE 800 W NINTH STREET JASPER, IN47546 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Accu-chek machines was posted on the med room door; area where machines are kept; conference room and via email to | COMPLETED | |
| SKILLED CARING CENTER OF MEMORIAL HOSPITAL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Time, "the glucometers were used for all SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ACCU-chek machines was posted on the med room door; area where machines are kept; conference room and via email to | | |
| SKILLED CARING CENTER OF MEMORIAL HOSPITAL (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Time, "the glucometers were used for all JASPER, IN47546 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Accu-chek machines was posted on the med room door; area where machines are kept; conference room and via email to | | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Accu-chek machines was posted on the med room door; area where machines are kept; conference room and via email to | | |
| time, "the glucometers were used for all REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE ACCU-chek machines was posted on the med room door; area where machines are kept; conference room and via email to | (X5) MPLETION | |
| were used for all on the med room door; area where machines are kept; conference room and via email to | DATE | |
| were used for all where machines are kept; conference room and via email to | | |
| conference room and via email to | | |
| | | |
| I I control nurse sent out a notice to | | |
| the nurses use alcohol the rest of the hospital and the "Equipment Cleaning and | | |
| SWADS TO Clean the High Touch Cleaning" policy was | | |
| glucometer between revised to address the use of PDI Super Sani-cloths to clean | | |
| each natient " and disinfect the Accu-chek | | |
| Machines. On 4/1/11, the "Accu-chek Glucose Testing" | | |
| policy (See Exhibit N) was | | |
| On 3/24/11 at 8:30 a.m. revised to refer to the "Equipment Cleaning and High Touch | | |
| during an interview with Cleaning" policy (See Exhibit O) | | |
| the Infection Control for cleaning the machines also. 2. Describe how the facility reviewed | | |
| Nurse (RN #2), she | | |
| be allected by the same deficient | | |
| the facility took to correct the | | |
| several glucometers in deficient practice for any client the facility identified as being | | |
| the lab that could be affected. On 3/24/11 the facility | | |
| used. She was not received a list of approved disinfectants from the | | |
| familiar with any | | |
| 7 Tood one machines. The FB1 | | |
| use to clean AND disinfect the | | |
| (Centers for Disease machines. The facility checked the FDA website and the | | |
| Control) regarding the ingredients in the PDI Super | | |
| recommendation to not Sani-cloths are recommended for disinfecting. (FAQ on PDI Super | | |
| Sani-cloth and a fax from Roche | | |
| on acceptable active disinfecting solutions to use on the Accu-chek | | |
| Solutions to doe on the Acces office | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|----------------------|---|--------|--|--|---------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | | COMPL | |
| | | 155305 | B. WIN | | | 03/24/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIEI | ₹ | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| SKILLED | CARING CENTER | R OF MEMORIAL HOSPITAL | | | NINTH STREET R, IN47546 | | |
| | | | | <u>. </u> | i | | (7/5) |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | 1 | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| | cleaning a | agent for | | | inform system). (See Exhibit | חח | |
| | glucomete | • | | | K and L) The facility had the Super Sani-cloths in stock and | | |
| | giucomete | 515. | | | prior to the next set of | | |
| | | | | | Accu-cheks that were perform | ied | |
| | A current | policy and | | | on 3/24/11 at 3:30pm, all Accu-chek machines were | | |
| | | | | | disinfected with PDI | | |
| | • | e, originally | | | Super Sani-cloths. The two | | |
| | dated 6/09 | 9 with review | | | Accu-chek machines that are used in the facility were | | |
| | and revisi | on 2/10, was | | | disinfected with the PDI Supe | r | |
| | l | • | | | Sani-cloths between each | | |
| | provided by RN #2 on | | | | remaining resident (Resident #122, #126, #127 | | |
| | 3/24/11 at | :8:30 a.m. The | | | and #129) (Resident # 21 was | ; | |
| | policy was | s titled | | | discharged) who required glud | | |
| | ١. ٠ | | | | monitoring. The Administrator and Director of Nursing begar | | |
| | "Equipme | nt Cleaning and | | | educating all nurses on 03/24 | /11 | |
| | High Touc | ch Cleaning" | | | at 3:30pm. (See Exhibit M) Ir | | |
| | and indica | • | | | addition, a memo regarding the change in procedure regarding | | |
| | | | | | the disinfecting of | 9 | |
| | following: | "Policy: | | | Accu-chek machines was pos | ted | |
| | Medical d | evices that | | | on the med room door; area where machines are kept; | | |
| | | ontact with | | | conference room and via ema | | |
| | | | | | all staff. On 3/25/11, our infection control nurse sent out notice t | | |
| | intact skin | but not | | | the rest of the hospital and the | | |
| | mucous m | nembranes | | | "Equipment Cleaning and Hig | | |
| | | | | | Touch Cleaning" policy was revised to address the use of | | |
| | l | ning and low | | | PDI Super Sani-cloths to clea | n | |
| | level disin | tection. | | | and disinfect the Accu-chek | | |
| | Disinfecta | nt should be | | | Machines. The "Accu-chek Glucose Testing" policy (See | | |
| | | | | | Exhibit N) was revised to refe | r to | |
| | | ental Protection | | | the "Equipment Cleaning and | | |
| | | | | | High Touch Cleaning" policy (| See | |
| | | | | | | | I |

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|--|----------------------------|------------------------------------|----------|--|------------------|------------|--|
| AND PLAN OF CORRECTION | | | | BUILDING | | | COMPLETED | |
| | | 155305 | B. WIN | | | 03/24/2011 | | |
| NAME OF PROVIDER OR SUPPLIER | | | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | | |
| SKILLED CARING CENTER OF MEMORIAL HOSPITAL | | | 800 W NINTH STREET JASPER, IN47546 | | | | | |
| (X4) ID | | | | ID | 1 | | (X5) | |
| PREFIX | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION | |
| TAG | | | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | IE | DATE | |
| | Agency (EPA) | | | | Exhibit O) for cleaning the machines also. 3. Describe to | he | | |
| | registered | l | | | steps or systemic changes the | , | | |
| | • | | | | facility has made or will make ensure that the deficient pract | | | |
| | | alcohol 70% | | | does not recur, including any | ice | | |
| | alcohol p | ads) | | | in-services, but this also should | | | |
| | Hydrochlo | oride (Bleach | | | include any system changes y made.Revised and instituted t | | | |
| | 1 | (2.00.0 | | | following policies: "Accu-chek | | | |
| | wipes) | | | | Glucose Testing" policy (See | | | |
| | Quaternaı | ry ammonium | | | Exhibit N) and the "Equipmen Cleaning and High Touch | t | | |
| | germicida | l detergent | | | Cleaning and riigh fouch Cleaning policy (See Exhibit | | | |
| | • | | | | O)Explanation and demonstra | | | |
| | solution (Quat 256) | | | | was provided to nurses; memo | ٥ | | |
| | Amerse (0 | Only in certain | | | regarding the change in procedure regarding the | | | |
| | situation, | as | | | disinfecting of Accu-chek | | | |
| | listed)Pro | | | | machines was posted on the r room door; area where machin | | | |
| | 1 ′ | | | | are kept; conference room and | d | | |
| | Equipmer | nt Cleaning: | | | via email to all staff. The Direct of Nurses will reinforce | tor | | |
| | Equipmer | nt shared | | | information during annual | | | |
| | | oatients needs | | | competencies for all Skilled | | | |
| | · - | | | | Caring Center nurses that are scheduled 4/11/11, 4/19/11, | | | |
| | to be clea | ned after each | | | 4/20/11 and 4/22/11. 4.Describ | | | |
| | use to red | luce | | | how the corrective action(s) w be monitored to ensure the | ill | | |
| | transmission of organisms Check list for suggested cleaning product for equipment" | | | | deficient practice will not recui | r, | | |
| | | | | | i.e., what quality assurance program will be put into | | | |
| | | | | | place.Infection control nurse v | vill | | |
| | | | | | be responsible to have | | | |
| | | | | | appropriate disinfectant availa for staff to use to disinfect | bie | | |
| | | | | | Accu-chek machines against | | | |
| | | | | | pathogenic agents. The Director of Nurses will conduct monthly | | | |
| | | | | | Or Marises will conduct monthly | ' | | |
| | • | | - | | • | | | |

| | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|---------------------------------------|----------------------------|--|-----------------------|-------------------------------|--|
| 155305 | | | A. BUI B. WIN | LDING IG | | 03/24/2 | | |
| NAME OF PROVIDER OR SUPPLIER | | | ' | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| SKILLED CARING CENTER OF MEMORIAL HOSPITAL | | | 800 W NINTH STREET JASPER, IN47546 | | | | | |
| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIES | | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) COMPLETION | | |
| TAG | 1 | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | DATE | |
| | At 8:50 a.r a docume provided by regarding recommer Accu check document "ACCU -C System Of Manual Hot System. A surfaces where the surfaces where | m. on 3/24/11, nt was by the DoN manufacturer dations for ck [facility's er name]. The was titled HECK Inform perator's bw to Clean the Wipe the with a soft cloth mpened (NOT y the meter ase unit y after You may also urfaces with a | | | random monitoring of nurses performing glucose testing to ensure nurses are disinfecting Accu-chek machines with properties of the propert | per e mes en | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155305 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED 03/24/2011 | | |
|--|-----------------------|--|-----|------------|--|-----|--------------------|
| 155305 | | B. WING | | | 03/24/2 | UT1 | |
| NAME OF PROVIDER OR SUPPLIER | | | | | DDRESS, CITY, STATE, ZIP CODE | | |
| SKILLED | CARING CENTER | OF MEMORIAL HOSPITAL | I . | | R, IN47546 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | | ID EFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| TAG | ` ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | AG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΤE | COMPLETION DATE |
| | with 70% | isopropyl | | | | | |
| | alcohol, fu | ıll strength | | | | | |
| | Warning: | Do not use | | | | | |
| | cleaners of | containing the | | | | | |
| | chemicals | ether, | | | | | |
| | polyhexan | nide, phenol, or | | | | | |
| | prepared : | solus or wipes | | | | | |
| | contain ga mixture of | | | | | | |
| | bleach an | d detergent on | | | | | |
| | the ACCU | -CHEK Inform | | | | | |
| | meter. Us | se of cleaners | | | | | |
| | containing | these | | | | | |
| | chemicals | could result in | | | | | |
| | damage to | o the | | | | | |
| | ACCU-CH | IEK inform | | | | | |
| | meter <i>i</i> | Acceptable | | | | | |
| | active ingr | redients are: | | | | | |
| | water, soa | ap, 70% (or | | | | | |
| | less) isopr | opyl alcohol, | | | | | |
| | 1:10 dilution | on of sodium | | | | | |
| | hypochlor | ite, ammonium | | | | | |
| | chloride (d | quaternary | | | | | |
| | | | | | | | |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES | | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|-----------------------------------|--|--|---|--|-----|----------------------|--|
| AND PLAN OF CORRECTION | | | | A. BUILDING | | | COMPLETED 03/24/2011 | |
| 10000 | | B. WING | | | 711 | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | 1 | ADDRESS, CITY, STATE, ZIP CODE NINTH STREET | | | |
| SKILLED CARING CENTER OF MEMORIAL HOSPITAL | | | | 1 | R, IN47546 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) | |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION DATE | |
| | ammoniur | n | | | | | | |
| | compound | ls)" | | | | | | |
| | 05 2/24/4 | 1 at 0.05 a m | | | | | | |
| | | 1 at 9:05 a.m. interview with | | | | | | |
| | _ | e indicated the | | | | | | |
| | • | meters in the | | | | | | |
| | medication | n room were | | | | | | |
| | the ones u | ised for | | | | | | |
| | residents. | She indicated | | | | | | |
| | she currently had two | | | | | | | |
| | residents | who got | | | | | | |
| | accucheck | ks at 7 a.m. and | | | | | | |
| | 4 p.m. Sh | e was also | | | | | | |
| | • | another resident | | | | | | |
| | who receiv | ved | | | | | | |
| | accuchecks four times | | | | | | | |
| | per day. S | he indicated | | | | | | |
| | the nurses | s clean the | | | | | | |
| | glucomete | ers with alcohol | | | | | | |
| | | etween each | | | | | | |
| | resident u | se and | | | | | | |
| | | | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155305 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVE COMPLETED 03/24/2011 | | | ETED | | |
|--|--|---|--------|---------------------|---|----|----------------------------|
| | PROVIDER OR SUPPLIER CARING CENTER | OF MEMORIAL HOSPITAL | B. WIN | STREET A | DDRESS, CITY, STATE, ZIP CODE NINTH STREET R, IN47546 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΤE | (X5) COMPLETION DATE |
| | demonstra | ated how it was | | | | | |
| | l ` | g an alcohol cleaned the lly. | | | | | |
| | the DoN polisting of received at There were residents in (Resident #126, #12) who were received go monitoring. | esidents who accuchecks. e 5 current in the facility #21, #122, 7, and #129) diabetic and flucose | | | | | |
| | glucometier. The en "Alcohol is listied in question comes in w metier. You would n | nanufactiurer of tihe nail indicatied our manual buti tihe when disinfecting tihe leed sometihing otiher ave iti tio tihe hospitial tio | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155305 | | (X2) MULTIPLE CONST A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 03/24/2011 | | | | |
|--|---|--|--|----------------------|--|--|--|
| | NTER OF MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 800 W NINTH STREET JASPER, IN47546 | | | | | |
| PREFIX (EACH D | MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PERCEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | | |
| creatie tihei | own cleaning policy" | | | | | | |
| 3.1-18(b)(1) | | | | | | | |